Kansas
Department of Health and Environment
Division of Health Care Finance

P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884

CIVIL RIGHTS COMPLAINT

This form is to be used to record either oral or written Civil Rights Complaints as they are received. The completed form shall be provided to the Eligibility Policy unit of Kansas Department of Health and Environment, Division of Health Care Finance.

Complainant (Last, First and Middle Name)			KDHE Area
Address			
City	State	Zip	Telephone
Date of Client's Complaint	Date of Response to Client's Complaint		Date of Completed Corrective Action

Definition of a Civil Rights Complaint: A verbal or written allegation of discrimination which indicates that the Medical Assistance Program is administered and operated in such a manner that it results in disparity of treatment or delivery of benefits provided to persons or groups of persons based on race, color, national origin, age, sex, disability, political belief or religion.

Date(s) on which the act(s) occurred
Description of incident(s)/act(s) which led to allegation(s) of discrimination.
Names, Titles and addresses of persons having knowledge of incident(s)/act(s).
Action(s) taken and Date(s) of corrective action(s).

Distribution: Original – Case File, Copy – Central Office – KDHE Eligibility Policy